



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

AVERA MEDICAL GROUP

**Respondent Name**

INSURANCE CO OF THE STATE OF PA

**MFDR Tracking Number**

M4-15-2168-01

**Carrier's Austin Representative**

BOX NUMBER: 19

**MFDR Date Received**

March 17, 2015

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We feel the claim should be allowed. We are a group of nine providers. The referenced patient has seen other providers in our clinic and we have received payment on the services for those providers, even though they were not listed as his treating doctor. We just recently received the commissioner order approving a change in his treating doctor from one provider to another provider in the group (Dr. Winkelbauer to Dr. Banks). This is the 1<sup>st</sup> we knew of any requirement that he see only one specific doctor. Also, he saw a different provider (Jenna Jacobs) in our group on 3/27/14 and the insurance company paid on that charge."

**Amount in Dispute:** \$120.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). As noted in the prior medical fee disputes from this provider, all current dates of services are currently being adjudicated at the Division of Workers' Compensation in the Lubbock Field Office on extent of injury. Therefore, this date of service should be dismissed and not heard through Medical Fee Dispute Resolution at this time."

**Response Submitted by:** AIG

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2014	CPT Code 99214	\$120.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §188.22 sets out the guidelines for the responsibilities of the treating doctor.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 1 – Workers' compensation jurisdictional fee schedule adjustment.
- 3 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- 2 – Not treating doctor.

### **Issues**

1. Were the services provided to the injured worker initially denied for extent of injury?
2. Was the health care rendered to the injured employee performed by the treating doctor?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code §133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:

Former 133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment of a medical bill; and (2) the injured employee when payment is denied because the health care was... (C) Unrelated to the compensable injury, in accordance with §124.2 of this title... (g) an insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: (3) the condition for which the health care was provided was not related to the compensable injury.

The Division finds that the carrier failed to raise the issue in accordance with DWC rules for disputed CPT Code 99213. Therefore, has waived the issue of extent-of-injury. As a result, MFDR has jurisdiction over the disputed issues, pursuant to Texas Labor Code §416.031.

2. In accordance with 28 Texas Administrative Code §180.22(c), the treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommended all health care reasonable required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section. Review of the documentation finds that the requestor has not submitted sufficient evidence that the injured employee was referred to the doctor that rendered the treatment.
3. For the reason stated above, the service in dispute is not supported.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 30, 2015  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**